Psychotherapy of Schizophrenia

Tracy D. Eells, Ph.D.

Major advances in the pharmacological treatment of schizophrenia in the past several decades have overshadowed a small but steady and encouraging line of recent research aimed at treating schizophrenia psychotherapeutically. Tempered by largely disappointing efforts in the past, contemporary psychotherapy models for schizophrenia are more modest and pragmatic in their goals and are viewed as part of comprehensive treatment in which pharmacological interventions serve as a foundation. Historically, psychotherapy for schizophrenia was based on psychodynamic or interpersonal theory, aimed at fundamental personality change, was long-term in nature, and viewed schizophrenia as interpersonal in origin.[1] Newer models understand schizophrenia as a biologically based disorder that can be managed in part by learned and practiced coping strategies. They also assume a diathesis-stress model to explain symptoms and the course of the illness. Furthermore, they emphasize adaptation and adjustment, are more empirically based, are sometimes short-term in focus, and are cognitive-behavioral or multimodal in theoretical orientation. In this article I will review these trends and new findings, beginning with an article that summarizes the history of psychotherapy for schizophrenia. The seven articles reviewed are not meant to be comprehensive; they reflect the results of a literature search using the keywords "psychotherapy and schizophrenia" as well as examining reference lists of the articles retrieved.

ABSTRACTS

Fenton WS: Evolving perspectives on individual psychotherapy for schizophrenia. Schizophrenia Bulletin 2000; 26(1):47–72

Summary: This article provides a history of theory about individual psychotherapy for schizophrenia as well as a literature review of randomized clinical trials that have evaluated individual psychotherapy of schizophrenia. The authors note that the most common treatment for patients with schizophrenia is a combination of prescription antipsychotic medications and some form of individual psychotherapy. In their view, psychotherapy of schizophrenia has been guided historically more by ideology and deference to authoritative opinion than by a foundation of empirical evidence.

The authors identify two theoretical traditions in the history of psychotherapy for schizophrenia. The "investigative" trend grew from the psychoanalytic and Sullivanian traditions and emphasizes the alleviation of emotional difficulties and the elimination of symptoms. The therapy focuses on a thorough examination of the patient's life history and current relationships and on the doctor–patient relationship. Patients with schizophrenia are seen as struggling with basic mistrust and the expectation that others will harm them. Their relationships are marked by ambivalence involving both a longing for merger and withdrawal based on a terror of closeness. Weak or absent ego boundaries result in a failure to differentiate one's own thoughts and impulses from those of others. Therapeutic efforts called for intense focus on establishing a relationship with the patient. Key therapist attributes were seen as basic respect for the patient and an interest in and capacity to tolerate intense affect, dependency, and ambiguous communication.

The "supportive" tradition of psychotherapy for schizophrenia is grounded in the medical model and

has been the preference of biologically and pharmacologically oriented clinicians. The treatment emphases are pragmatic and symptom-focused rather than aimed at personality change. Favored therapist interventions include defining reality, offering direct reassurance, giving advice, urging modification of expectations, and actively organizing the environment when necessary.

The research literature review covers three epochs. The first, 1960 to 1975, focused on a medication-versus-psychotherapy paradigm. In six randomized clinical trials reviewed, the authors concluded as follows: 1) no study supported the efficacy of individual psychotherapy as a sole treatment for schizophrenia, and medication-treated groups always demonstrated superior outcome on average whether or not psychotherapy was offered; 2) studies of psychoanalytic psychotherapy that included a follow-up evaluation found no clear advantage for therapy plus drugs versus drugs alone, although one study suggested a better outcome among patients of two highly experienced therapists; and 3) among the forms of psychotherapy evaluated, the most promising was a practical, problem-solving approach emphasizing resolution of current life situational problems.

Research during the second epoch, the 1980s and early 1990s, compared different forms of psychotherapy when combined with medication. This body of research showed that intensive investigative psychotherapy combined with medications appeared to offer no advantage over less intensive and less costly therapy approaches. Further conclusions were that the distinction between supportive and insight-oriented therapy appeared less meaningful when treating patients with schizophrenia. However, a positive therapeutic alliance was associated with better medication compliance and better outcome. The generally disappointing results from randomized clinical trials and follow-up studies contributed to a decline in the influence of a psychodynamic and intensive individual psychotherapy approach for schizophrenia, and to the increased ascendancy of the biological paradigm.

The third epoch, beginning in the early 1990s and continuing to the present, emphasizes cognitive-behavioral interventions, briefer treatments, and improved adaptation to schizophrenia. Informed by reappraisals of past therapeutic approaches, Hogarty and colleagues[2] developed Personal Therapy (PT) for recently discharged patients with chronic or subchronic schizophrenia. PT is informed by neuropsychological aspects of schizophrenia and includes three phases, each with associated goals and techniques. The overall aims are to enhance personal and social adjustment and to forestall relapse. The results of two three-year randomized clinical trials[3,4] found good compliance for PT versus supportive therapy and family psychoeducational treatments. Fifty-four percent of patients advanced to the third phase of PT; the greatest success regarding relapse occurred for PT patients with stable living arrangements.

(The cognitive-behavioral treatments that constitute the second major strand of research in the third epoch are the focus of the present article.)

Comment: This is an excellent, objective review.

Tarrier N, Yusupoff L, Kinney C, McCarthy E, Gledhill A, Haddock G, Morris J: Randomised controlled trial of intensive cognitive behaviour therapy for patients with chronic schizophrenia. British Medical Journal 1998; 317:303–307

Summary: Eighty-seven patients with chronic schizophrenia who experienced persistent hallucinations or delusions were assigned to one of three treatment groups by use of a randomized procedure that included stratification according to severity of symptoms and gender. The treatments were intensive cognitive-behavioral therapy (CBT) and routine care, supportive counseling and routine care, and routine care alone. The CBT focused on teaching patients methods of coping with their symptoms, providing training in problem solving, and teaching strategies to reduce risk of relapse. Routine care consisted of medication management and monitoring outpatient follow-up. Twenty sessions were provided during a period of 10 weeks. Results at 3 months after treatment showed significant improvements in the CBT group, but not in the other two groups. The CBT group showed reductions in symptom severity and number of positive symptoms. In addition, significantly more patients treated with CBT showed an improvement of 50% or more in their symptoms.

Comment: This is one of the better-designed studies testing efficacy of CBT in patients with schizophrenia. The sample size is relatively large, and a control group was included. The treatment was relatively intense, was highly structured, and was delivered in an individual format. The findings are particularly noteworthy in that they occurred in addition to routine care.

Kuipers E, Fowler D, Garety P, Chisholm D, Freeman D, Dunn G, Bebbington P, Hadley C: London–East Anglia randomized controlled trial of cognitive-behavioural therapy for psychosis. British Journal of Psychiatry 1998; 173:61–68

Summary: Forty-seven patients who suffered symptoms of psychosis and underwent either cognitive-behavioral therapy and routine medication care or routine care alone were followed up l8 months after baseline. Using the Brief Psychiatric Rating Scale (BPRS) as the primary outcome measure, analyses showed that the CBT group maintained treatment gains that had been achieved by the end of treatment. The routine care group showed no improvement. As compared with the routine care group, the CBT group showed a statistically significant reduction in distress from delusions and a reduction in preoccupation with delusions. Using a 5-point change in BPRS scores as a measure of reliable clinical change, the authors found that 65% of the CBT group showed reliable clinical improvement as compared with 17% of the routine care group at follow-up. These authors also conducted an economic evaluation of their treatment and found that the costs of CBT appeared to have been offset by reduction in service utilization and associated costs during the 9-month follow-up period.

Comment: This study complements that by Tarrier et al.[5] in finding that changes achieved using CBT may be maintained 9 months after the conclusion of treatment. Note that the treatment provided by Kuipers and colleagues occurred over a 9-month time span as compared with the 10-week treatment provided in the study by Tarrier et al. The economic analysis, although based on a small sample, suggests that cognitive-behavioral therapy may lead to reduced healthcare system costs in the longer run despite higher costs at the outset of treatment.

Jakes S, Rhodes J, Turner T: Effectiveness of cognitive therapy for delusions in routine clinical practice. British Journal of Psychiatry 1999; 175:331–335

Summary: The purpose of this study was to assess the effectiveness of cognitive therapy on patients with delusions who were seen in routine clinical work as opposed to patients seen as part of a randomized clinical trial. Eighteen patients with chronic delusions were treated with cognitive therapy that aimed at reducing the intensity of delusional beliefs. The treatment used cognitive challenging, reality testing, and normalization techniques. The authors used a single-case multiple-baseline experimental design that included a control treatment focusing on a problem unrelated to a patient's delusional beliefs. Of the 18 patients, 6 showed reduced conviction in their delusions during cognitive therapy, but not during the control treatment; 7 patients did not change; and 5 showed a variable response. No patients showed a complete absence of conviction in their delusions.

Comment: Although lacking the methodological rigor of other studies I am reviewing, this one has an advantage in that it replicates those findings in a more typical clinical setting. That is, it suggests that treatment effects found in relatively highly controlled clinical trials research hold up in a typical clinical setting.

Pinto A, Pia SL, Mennella R, Giorgio D, DeSimone L: Cognitive-behavioral therapy and clozapine for clients with treatment-refractory schizophrenia. Psychiatric Services 1999; 50(7):901–904

Summary: This study randomly assigned 41 treatment-resistant patients with schizophrenia who had recently started clozapine to either a cognitive-behavioral therapy (CBT) plus social-skills training group or individual supportive psychotherapy. Treatment lasted 6 months. CBT plus social skills training included modeling, rehearsal, positive reinforcement, in vivo exercises, and homework assignments. Specific interventions focused on improving patients' ability to manage psychotic symptoms, disputation of irrational beliefs when possible, and enhancing a patient's ability to identify and monitor stress levels. Both groups showed statistically significant change at the end of treatment as measured by the Brief Psychiatric Rating Scale, a scale measuring positive symptoms, and a third scale measuring negative symptoms. The CBT plus social skills training group showed greater improvement, however.

Comment: Despite methodological problems, this study provides further evidence that cognitive-behavioral therapy plus social skills training provided on an individualized basis may be beneficial to patients with schizophrenia in reducing both positive and negative symptoms. It is encouraging to see these findings emerge from a different practice setting in a different country than those reported in previous studies.

Wykes T, Parr A, Landau S: Group treatment of auditory hallucinations: exploratory study of effectiveness. British Journal of Psychiatry 1999; 175:180–185

Summary: Group cognitive-behavioral treatment for psychotic symptoms was explored. Twenty-one patients diagnosed with schizophrenia who had experienced treatment-resistant hallucinations for an average of 14 years underwent 6 treatment sessions emphasizing individual power and control, psychoeducation, and coping strategies. Treatment followed a 6-week waiting time control condition. Results indicated reduced distress from auditory hallucinations and reduced disruption caused by the voices. In addition, there were increases in insight and improvement in coping strategies. These effects were maintained 3 months after treatment concluded. No changes were observed in measures of depression or anxiety.

Comment: Although this study lacks a control group and the effects were relatively small, it suggests that group treatment for schizophrenic patients that specifically targets insight into the illness, auditory hallucinations, and self-esteem may be helpful. The authors emphasized that their results are comparable to those obtained in individual treatment, but are more cost-effective.

Sensky T, Turkington D, Kingdon D, Scott JL, Scott J, Siddle R, O'Carroll M, Barnes TRE: A randomized controlled trial of cognitive-behavioral therapy for persistent symptoms in schizophrenia resistant to medication. Archives of General Psychiatry 2000; 57(2):165–172

Summary: The efficacy of manualized cognitive-behavioral therapy developed specifically for schizophrenia was compared with a nonspecific befriending control intervention. Ninety patients received an average of 19 individual treatment sessions over 9 months in addition to their pharmacological treatment. CBT treatment focused on developing a collaborative understanding of the development of symptoms, critically analyzing beliefs about the origin and nature of auditory hallucinations, use of voice diaries, reattribution of the cause of the voices, Socratic questioning to address delusions, and other aspects of thought disorder. Both treatments led to significant reductions in positive and negative symptoms of schizophrenia as well as in symptoms of depression. At a 9-month follow-up evaluation, patients who had received cognitive therapy showed continued improvement, but those in the befriending group did not.

Comment: This is one of the best-designed studies reviewed and shows results comparable to the others. A key aspect of the study is that the patients were selected because their symptoms persisted despite treatment adherence.

CONCLUSIONS

These outcome studies are welcome in light of the relative paucity of randomized clinical trials addressing the psychotherapy of schizophrenia and the general lack of good evidence, prior to these reports, demonstrating efficacy.[6] A key feature of the studies discussed is that they are highly symptom-focused, emphasize teaching patients skills to better manage their difficulties, and are relatively more limited in goals that are pursued, compared with earlier research in the psychotherapy of schizophrenia. In general, the best results occurred with the combination of focused psychotherapy, medication management, and a stable living environment for patients. Further work is needed because some patients do not respond well or completely to medication alone, and also because patients with schizophrenia and their families consistently rank psychotherapy as a highly valued service.[7–9]

Dr. Eells is a clinical psychologist and Associate Professor in the Department of Psychiatry and Behavioral Sciences, University of Louisville, Louisville, KY.

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